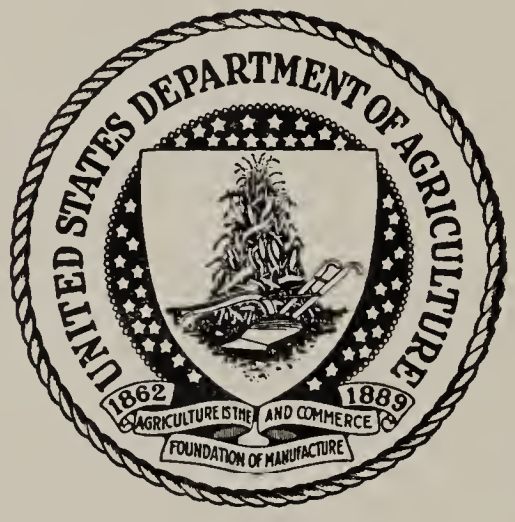
U.S. FARM SECURITY ADMINISTRATION

Group medical care for farmers 1941



FSA–Pub. 75

Group Medical Care for Farmers

Farm Security Administration
U. S. Department of Agriculture
Washington, D. C.

Group Medical Care for Farmers

How to get medical care and hospital service has always been a problem for farm families with thin pocketbooks. Early in 1936, a group of families who were borrowers from the Farm Security Administration got together to figure out a way to pay for the doctors' services and hospital care they needed.

Within five years, their idea developed into one of the biggest voluntary group medical care programs in the world. It serves half a million men, women, and children—more than 100,000 farm families—in about 900 counties of 35 States.

The program was started in cooperation with the organized medical profession, in order to get doctor and hospital services for Farm Security Administration borrowers and their families at a price they could afford.

These families could not get such services by themselves. They were among the 1,700,000 farm families who in 1936 were trying to pay rent, operate their farms, and feed and clothe themselves on an average income of only about $500 a year. Such incomes usually couldn't be stretched far enough to provide the necessities for good health. Thousands of families lived on farms without sanitary facilities. Meal and molasses or pork and potatoes were common menus day after day. There was little money, if any, for doctor bills.

A New Start

Most of these families were farming poor land by poor farming methods, and depending for all their income from a single crop. Few of them had enough equipment to run their farms efficiently. Many were on relief.

414955°—41

Since 1934, nearly 900,000 such handicapped farm families have been helped by the Farm Security Administration to get a new start.

To those who can't borrow money anywhere else, the Farm Security Administration makes loans for livestock, seed, equipment—whatever the families need to run their farms on a sound basis. Trained farm and home management supervisors help each family prepare yearly operating plans, and carry out practical methods of farming and home management. Instead of raising a single cash crop, FSA borrowers plant two or three, so if one fails they can sell another. They produce most of their own food, raise feed for their livestock, and follow sound soil-improving practices.

Better Food—Better Health

As PART of this job of rehabilitation, the Farm Security Administration found it necessary to help develop a broad health program. Better nutrition, improved housing and sanitation, and full use of public health facilities have been stressed, along with plans for medical, dental, and hospital care.

Health of farm families is essential to their own economic success. It is also essential to the Nation's defense efforts. In proportion to population, more recruits come from rural than from urban areas; and more than 40 percent of all selectees are being rejected because they can't measure up physically. Poor diet is blamed for a third of the rejections.

To get better nutrition, FSA borrowers are urged, first of all, to make their farms supply their tables. It is the cheapest way they can live, and it is the only sure way they can get three square meals a day.

With advice about how much and what kind of food they need for year-round balanced meals, these families raise gardens and use part of their loans to buy cows, hogs, chickens, canning equipment, and other things they need to produce and preserve food.

While the farm supervisor gives the farmer technical counsel on good farming practices, the home management supervisor

shows the wife how to can and store food, to plan and cook balanced meals.

In 1940, FSA borrowers produced an average of $264 worth of food and other products for their own use, compared with $163 worth in the year before they came to FSA for aid. They had canned only an average of 139 quarts of fruits and vegetables before; but last year they canned 266 quarts.

After eating enough of the right kind of food for a while, these people began to "feel better." For example, in the spring of 1941, a group of physicians gave complete physical examinations to families of FSA borrowers in seven southeast Missouri counties. They found a striking relationship between anemia and the length of time the families had been on the FSA program.

"Almost all persons with a hemoglobin percentage below 80 had been on the program for a relatively short time," the physician in charge reported. "There was little anemia among families who had been on the program for two years or more."

The Need for Medical Care

But living on low incomes and poor food year after year had taken its toll on health among most of these families. In 21 typical counties of 17 States, thorough physical examinations were given in 1940 to FSA borrowers and their families—11,497 people. An average of more than 3½ defects was found for every man, woman, and child. Poor teeth was the most common defect. Teeth, physicians and dentists agree, are directly affected by diet. About one in every 10 children under 15 years of age was 16 percent or more underweight.

Most families had accumulated defects over the years, as a result of lack of medical and dental care. For instance, 54.2 percent of wives in white families were suffering from childbirth injuries; 8.5 percent of heads of families had hernias; 60.5 percent of all children had defective tonsils.

The first evidence that poor health was keeping many farm families from doing a good day's work came from the supervisors in the field. Soon after the rehabilitation program began, many reports came in which read something like this:

"Jim Black neglected his work all spring. His neighbors

said he was lazy because he was slow about his work. Two weeks ago he was unable to get out of bed and the doctor was called. We found that Jim had a hernia. He hadn't talked about it because he was ashamed that he couldn't pay for an operation."

Not all defects came to light like that, but many other "lazy" or "shiftless" farm men and women were actually in poor health. They were making little progress, although they had the same opportunities as other families who were getting back on their feet and paying off their loans.

In States where surveys were made, poor health was the main cause of 15 to 20 percent of the complete failures.

Often these people didn't have money to pay a doctor, so they didn't call one until some member of the family became seriously ill. Then, many times the farmer either had to let the doctor and hospital bills go unpaid, or else settle them by selling off some of his much-needed livestock or equipment.

If families were to become self-supporting, taxpaying citizens again, they had to have medical care when they needed it, and without selling their only cow or mule to pay for it.

How the Program Works

MANY of them have solved the problem the way Sam Gordon did. Sam figured that ordinarily it would have cost him $175 to have his daughter's bad appendix removed. But the $15 he had already paid into the "pool" covered everything.

The "pool" was Sam's name for the FSA medical care plan in his Alabama county. The same pool that year paid his physicians 91 percent of all bills submitted.

In general, the FSA program is based on the principle of insurance. Each family pays a fixed sum at the beginning of a 12-month period, whether they need immediate medical care or not. It is their annual "bill for health." It insures them of medical care and against the worry of unpaid bills. And they can call a doctor to keep a bad cold from turning into pneumonia.

Before a medical care plan is started in any State, an agreement is reached first with the State Medical Association, and then with each of the county medical societies in counties

where plans are to be put into operation. Details are usually worked out with representatives of local physicians, hospital boards and pharmacists, and vary considerably in accordance with local needs.

In basic principles, however, all plans are alike. The family can choose any doctor who agrees to serve the group. The annual fee is the amount a family can afford to set aside for medical care, figured on the basis of average income of FSA borrowers in the area. Paid a year in advance, all fees are handled by a bonded trustee.

The annual cost usually ranges from $15 to $35 a family. The difference is due to differences in incomes, in services available, and sometimes in the size of the family. A typical fee is $18 for a man and his wife, plus $1 for each child, with a $26 maximum. The amount is budgeted, along with other family living and farm operating expenses, and written into the annual farm and home plans. If they can scrape up the money, families pay the fees out of their own pockets. Otherwise, the amount is included in FSA loans, and repaid when the rest of the loans are repaid.

In return for their fees, the families usually are assured of ordinary medical care, including examinations, diagnosis and treatment; obstetrical care; emergency surgical care; some hospitalization, and ordinary drugs. Limited dental care is included in some plans.

Although these families can't spare enough money out of their meager incomes to cover correction of all chronic defects, provision often is made to correct handicaps which hinder progress.

There are two general types of organization. In one, FSA borrowers form an association governed through a board of directors chosen from among the group. Their treasurer pays the doctors' bills. In the other, a bonded trustee handles the funds. In this type, quite often the borrowers elect an advisory committee to represent their interests.

In either case, a small amount—usually 50 cents or a dollar per family—is deducted from the pool for administrative expenses. The trustee or treasurer divides the rest of the money into 12 equal parts, one for each month. If the allot-

ment is large enough to cover the month's total bills, they are paid in full. If not, each doctor gets an amount in proportion to the service he has given. If any surplus is left after bills are paid in full, it is carried over to the end of the year and prorated on unpaid bills.

All bills are examined and approved by a medical review committee of local physicians before they are submitted for payment. There are few padded bills, few unfair practices. Through their county medical societies, the doctors themselves handle any questions or problems of a medical nature.

Dental Care

DENTAL SERVICES provided under medical care plans usually are limited to emergency care, mostly to extractions and simple fillings. A group of farmers in Arkansas was the first to start a separate dental pool. Many others followed suit. Although this phase of the program is still considered experimental, more than 23,000 families in 163 counties are getting their teeth "fixed up" by pooling their funds to pay the dentist.

The number of dental plans is steadily increasing, probably because most low-income families who have neglected their teeth are glad to find a way to pay for having them repaired. For example, a Michigan farmer who pooled money with his neighbors for dental services, went to see a dentist for the first time in 27 years. After his decayed teeth were extracted, he said his rheumatism cleared up.

Plans for dental care are similar to those for medical care. They are set up in cooperation with State and local dental societies, and dental aspects of the plan are supervised by the profession. Based on average ability of the families to pay, fees are collected a year in advance.

Usually the plans provide such emergency services as extractions, treatment of infections, simple fillings, and preventive care. For these services, families pool their fees—usually $3 for each family, plus 50 cents for each person. A family of five pays $5.50.

Dental pools are divided into 12 monthly allotments. If a month's allotment is not enough to cover the month's bills,

payments are prorated. Reports show dentists are collecting more than 70 percent of the amount they would normally bill for the same services.

Care for Project Residents

SHARING the cost of medical needs came naturally for families on FSA homestead projects. They were good neighbors and good sharers anyway. About 15,000 families had moved from worn-out land or cut-over forest areas, to these compact rural communities where they have good land and good homes. Meeting often to mull over their community problems, or to discuss new farming practices, they had formed the habit of working together.

Medical care plans have been set up on 75 of the 148 homestead projects in the United States. Many were organized by the project residents themselves, who worked out special agreements with physicians and hospital staffs. Thirty-seven of these medical care plans serve only the project families, while the others serve both project families and FSA rehabilitation borrowers in the area.

Usually homestead families have free choice of physicians. A few projects, however, are located several miles from the nearest doctor. Doctors serve these by visits on certain days each week. Sometimes, too, a doctor will agree to move to a project for a guaranteed basic income.

Some families pay regular monthly dues in cash from the beginning, without help from the Farm Security Administration; others start by paying with FSA loan money, to be repaid when fall crops are sold.

With 100 to 200 families grouped together in these closely knit communities, precautions had to be taken against the outbreak of infectious and contagious diseases, and some projects were located in counties without public health services. To help provide such preventive care, nurses are employed by the Farm Security Administration on 45 homestead projects. In cooperation with State and local health departments, the nurses carry out a general public health nursing program. They work with families in the area who are not on projects,

too, either to supplement county health programs, or to provide needed service where it is lacking.

Medical Aid for Migrants

SELF-SUPPORTING medical care plans wouldn't work out for migrant farm families, who have no money for fees, and who are never in one place long enough to become part of a group. On the other hand, migrants cannot get medical relief from local agencies because they have no place to call home and cannot meet residence requirements.

Yet, these homeless people probably need medical attention more than any other group in the country. Poverty, malnutrition, exposure, and the insanitary conditions of their life along the Nation's highways make them easy prey to disease. These migrant farm laborers present a health problem which cuts across State lines.

To provide shelter for agricultural migrants, the Farm Security Administration has built 58 migratory labor camps in areas where there is a heavy seasonal demand for farm labor. Six more are under construction. The camps provide sanitary facilities and temporary shelter. Each camp has a health center in charge of a nurse, and an isolation unit for patients with contagious diseases. State health departments assist in providing immunization and other preventive measures. Arrangements for services of local physicians have been made with State and county medical societies. When necessary, patients are referred to surgeons or other specialists, and hospitalization is provided.

Since 1938, migrants in California and Arizona have received medical care through the Agricultural Workers Health and Medical Association. It is a nonprofit organization, assisted by grants from the Farm Security Administration. It is directed by representatives of the State health department and the State medical and dental associations of California, and by the State Medical Association of Arizona.

When migrants apply for medical treatment, they take out a membership in the Association, and select a physician from a list of those participating. The Association is billed for doctor or hospital services, for prescribed drugs, X-rays and

other diagnostic services, emergency dental care, and for special diets for patients suffering from malnutrition.

Cooperating local physicians usually take turns keeping regular office hours at camp clinics. They serve on alternate days, or for two or three weeks at a time.

When migrant workers can afford it, they are asked to repay part of the bills. As a token of appreciation, some of them do repay a few dollars, even though they need all their meager incomes for the staples of living and can spare none for medical care.

In July 1941, after a little more than three years of operation, the Agricultural Workers Health and Medical Association in California and Arizona had provided medical aid for 107,167 persons.

Similar corporations were organized early in 1941 in the Pacific Northwest, the Rio Grande Valley in Texas, and in Florida.

Sanitation Is Provided

In 1938, a campaign was started to bring about better sanitary conditions on farms of FSA borrowers. It is a discouraging business, at best, when country doctors are called to cure the "chills and fever" of patients who live in unscreened homes. Mosquito-borne malaria has been—in fact, still is—a common disease in some southern areas. So are typhoid fever, dysentery, and hookworm disease. Lack of sanitary facilities is mainly responsible.

Seventy percent of all farm homes in the country were inadequately screened in 1934. A fourth of them had no screens. Sanitary privies were scarce, and there was no privy of any kind on one farm out of every seven. Half the families had inadequate or insanitary water supplies.

In such areas, filth-borne disease rates were high. About three years ago, for example, a survey was made to determine the extent of hookworm disease in Georgia. It covered 10,297 people in 30 counties. Thirty-eight percent—nearly 2 out of every 5 persons examined—were infected. In one county 80 percent had the disease.

FSA field people had constantly hammered away at the need for better water supplies, screens, sanitary privies. But

many families had no money for them. Moreover, most FSA borrowers were renters or sharecroppers. Many moved to a different farm every year. They simply could not afford to spend money for improvements they might use only a short time.

Finally a way was found to make sanitation improvements on thousands of farms all over the country. Grants of money were made to borrowers for materials to build privies, to screen homes, and to make drinking water supplies safe. Farmers agreed to pay back the grants in work to improve their living conditions. Landlords became interested. The value of their investments was being increased. They cooperated by giving many tenants 3- to 5-year written leases, and paid for some of the improvements.

Other agencies helped. State and county public health departments gave technical advice, inspected the work and sometimes supervised it. WPA supplied labor to build privies. Window screens, screen doors, and well slabs were made, without charge for the labor, in National Youth Administration workshops.

Already the sanitation program has directly improved living conditions for thousands of rural people. At least 60,000 new privies have been built, about 35,000 homes screened, and 30,000 water supplies protected. Indirectly, it has affected many more, because the neighbors of FSA borrowers are improving their places. One Arkansas landlord told an FSA supervisor he had to paint his house and build a new privy "so it would look as nice as my tenant's." In one Missouri county 159 privies were built on farms of FSA borrowers—and 200 more were ordered by landlords for neighboring tenants.

Results of the Health Program

The FSA medical care program has "caught on." Many plans have been reorganized at the end of the first year to fit local conditions. But 95 out of every 100 are renewed each year, and new plans are being set up every month.

As a result, many farm families are getting regular medical attention for the first time in their lives, and paying for it. They used to go without a doctor rather than take "charity."

There have been some complaints. One man said he didn't think he would join the medical plan, "because on the average we don't use more than sixteen dollars' doctoring a year, and we don't think we can save by joining."

Another FSA borrower who had joined a dental care group wanted a cavity filled with gold. The dentist said gold fillings weren't in the bargain, and amalgam was just as good.

"Well, if I can't get a gold tooth, I don't want any," the farmer said. "I knew there was a catch in it somewhere."

But most families feel the same way as the DeMarco family in New Jersey. "We didn't have a doctor at all the past nine years," Mr. DeMarco said, "except three years ago when Joe died of lockjaw. If we'd of had the doctor in time, maybe our boy could've been saved. Now, it's different. My wife here has been laid up with heart trouble and if we didn't have a medical plan she couldn't get to the doctor. We had a bad year. The fruit didn't bring much and the tomatoes was spoiled by the weather. You never know what you might run up against."

It's the security they like best. One woman in Colorado said, "It sure takes off a lot of worry. You don't have to wait until a person's down sick before you call the doctor. Last year, Roberta had a bad earache. The doctor lanced it and said we did right not losing much time, because he could stop the infection. If it had been let go, it would have been mastoid."

Sometimes the families may trump up an ailment just to see if the plan works. Once they find out it does, the doctor is seldom bothered again with unnecessary calls. Occasionally the county supervisor has to talk to a family who persist in running the doctor ragged, but few have been asked to drop out. There is no difference in doctor-patient relationships in group medical care practice, as compared with private practice. And most doctors collect more money from the families taking part in a group plan than they did from the same families individually.

One Kansas doctor kept a record of what 42 families paid him over a three-year period. It came to 11 percent of the bills. Six months after these patients joined with their neighbors in a pool for health insurance, he was collecting 61 percent of his fees.

In Indiana a cooperating doctor said: "If a country doctor collects 40 percent, he's doing good. I'm collecting 100 percent from the medical care group." Most group medical care plans pay around 65 percent of the amount billed against them.

American Medical Association Comments

A REPORT of the Committee on Legislative Activities of the American Medical Association at its last annual meeting, included the following statement:

"Any plan to promote improvement in the collective family health among Farm Security Administration clients should redound to the general benefit. The aid given farm families which improves their economic condition and enables them to liquidate their obligations later has a sound economic basis. If the aforementioned rehabilitation plan is developed, it should receive the approval of the component county medical society and should be accomplished through that society.

"Your committee believes that the rehabilitation work done has been a valuable contribution to society, for the tendency is to restore self-respect to a family and to create a more independent outlook justifying the many loans, which in most instances are repaid."

Referring to the Farm Security Administration's policy of arriving at understandings with State medical societies, prior to making contracts, the American Medical Association adopted a report expressing "highest approval." The report states further that, "Your reference committee notes with pleasure the report of the rehabilitation work. Any attempt to restore health and self-respect to American families and to preserve individuality, independence, and security is to be commended."

How a Typical Plan Operates

THE FOLLOWING REPORT from a Midwestern State illustrates the operation of a typical medical care plan. In the county plan described, the families pay $30 annually for general practitioner care, emergency surgical care, prescribed drugs, limited hospitalization, and emergency dental care.

A deduction of $1 is made from each family's dues for administrative expenses. The funds are then divided into twelve monthly allotments. Hospital and drug bills are paid in full each month as preferred charges, and the balance of the monthly allotment is used to pay physicians' and dentists' bills. A record is kept of any bills not paid in full, and at the end of the year any accumulated monthly surpluses are applied against the unpaid balances still owed on such bills.

The county used as an illustration has a population of about 13,000. There are six practicing physicians, seven dentists, three hospitals and seven druggists in the county. All are participating in the program. There were approximately 175 rehabilitation families in the county during the period covered by the following report:

Report of County Medical Care Plan, August 1939 through July 1940

[Average monthly membership—162 families, 767 persons. Total membership dues at $30 per family per year—$4,888.58]

	Approved charges	Percent of total	Amount paid	Percent paid
All services	$5, 497. 03	100. 0	$4, 888. 58	88. 9
Physicians and surgeons	4, 327. 00	78. 7	3, 745. 49	86. 6
Hospitals	469. 93	8. 6	469. 93	100. 0
Drugs	296. 60	5. 4	296. 60	100. 0
Dental	232. 00	4. 2	205. 06	88. 4
Ambulance	7. 50	. 1	7. 50	100. 0
Administration	164. 00	3. 0	164. 00	100. 0

Summary of Services

Cases of illness	819	Office, home, and hospital calls per 1,000 persons	1,653
Surgery:		Drug prescriptions	491
Minor	25	Charge per prescription	$0.60
Major	8	Hospitalized cases	15
Obstetrical cases	13	Hospital days	98
Illness per 1,000 persons	1,068	Number of days per case	6.5
Office calls	1,008	Cost per case	$31.33
Home visits	143	Dental cases	96
Miles traveled (physicians)	1,330	Charges per case	$2.42
Hospital calls	117		

Monthly Payment

	Physicians' and surgeons' service				Emergency dental service	
	Approved charges	Amount paid	Percent paid	Approved charges	Amount paid	Percent paid
1939						
August	$297.00	$295.64	99.5	$4.00	$3.98	99.5
September	349.50	284.47	81.4	21.00	21.00	100.0
October	269.25	269.25	100.0	8.00	8.00	100.0
November	412.00	287.91	69.9	20.00	14.00	70.0
December	446.00	316.05	70.9	23.50	16.64	70.8
1940						
January	218.00	218.00	100.0	6.00	6.00	100.0
February	437.00	284.61	65.1	27.50	17.92	65.2
March	477.50	310.65	65.1	14.00	9.10	65.0
April	283.50	283.50	100.0	10.00	10.00	100.0
May	281.50	272.52	96.8	40.00	38.72	96.8
June	433.00	342.88	79.2	21.00	16.64	79.2
July	422.75	303.51	71.8	37.00	30.24	81.7
Accumulated balances	.....	276.50	.....	.....	12.82	.....
Total	$4,327.00	$3,745.49	86.6	$232.00	$205.06	88.4

	Hospital and drug services (all bills for these services were paid in full each month)		Charges for services received by families	
	Hospital	Drugs	Charges for service	Number of families
1939				
August	$69.15	$10.64	No service	12
September	67.40	6.55	0– 9.99	40
October	31.50	7.15	$10.00–$14.99	12
November	68.60	16.33	15.00– 19.99	19
December	27.75	33.89	20.00– 24.99	7
			25.00– 29.99	10
1940			30.00– 34.99	5
January	0	29.61	35.00– 39.99	6
February	50.50	44.07	40.00– 49.99	21
March	47.75	35.41	50.00– 99.99	21
April	22.50	24.43	100.00–149.99	9
May	43.88	33.15	150.00–200.00	2
June	6.00	22.75	.....	.....
July	34.90	32.62	.....	.....
Total	$469.93	$296.60	.....	.....

U. S. GOVERNMENT PRINTING OFFICE: 1941

tion.

rmers... 1941.